Medical History

Allergies, if any including medication:

_____

_____

_____

Immunizations, including tetanus status:

_____

_____

_____

Medications your child has recently, or is currently, taking:

_____

_____

_____

Chronic or existing diseases or medical problems (e.g. diabetes, epilepsy):

_____

_____

_____

Springfield Medical Care Systems, Inc.

Where People Come First

25 Ridgewood Road, Springfield, VT 05156

In An Emergency

_____

_____

_____

_____

_____

_____

Primary Care Doctor:

_____

_____

Phone Number: _____

Medical Insurance Carrier:

Subscriber Name:_____

_____

ID # _____

Group # _____

Springfield Medical Care Systems, Inc.

Where People Come First

25 Ridgewood Road, Springfield, VT 05156

Permission To Treat

FOR A MINOR CHILD

Springfield Medical Care Systems, Inc.

Where People Come First

Why Do I Need This Form?

Making certain your children are protected while you travel means more than getting a sitter. To be absolutely safe, you should provide written authorization for a responsible adult to approve any necessary emergency medical treatment.

Unless a child's injuries are life threatening, hospital personnel and physicians cannot treat him or her without parental or guardian consent. As a result, your child may suffer unnecessary discomfort while waiting for you to be reached to approve stitching of a cut or setting of a broken arm.

Avoiding the situation when traveling is easy. Each time you go out of town, complete the form on the right and provide the information requested on the back. A separate consent form is necessary for each of your children.

Please ask the adult that you have designated on the consent form to keep this brochure handy. It should be taken to a hospital or doctor's office if the child requires medical treatment.

Additional copies of this pamphlet can be obtained at any Springfield Medical Care Systems' location, or by calling Springfield Hospital at 802-885-2151.

Consent For Medical Treatment Of A Minor Child

I, (We) _____ and _____

I am (we are) the parent(s) or legal guardian(s) of _____

a minor, age _____ born _____, (date of birth)

_____

(Street address) (City/state)

I (we) authorize _____, who resides at

_____

(Street address)

_____

(City) (County)

_____

(State)

to seek medical care, including transportation to an emergency room, and consent to any necessary examinations, medications, procedures, or medical or special supervision.

For the period: From_____

To_____

Dated this _____ day of _____.

_____

(Signature of parent or guardian)

Witness_____

Witness_____

Springfield Medical Care Systems, Inc.

25 Ridgewood Road, Springfield, VT 05156

802-885-2151